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SUBMITTED TO THE INSURANCE AND REAL ESTATE COMMITTEE
Thursday, March 17, 2022

HB 5447, An Act Concerning Prior Authorization For Health Care Provider Services

We appreciate this opportunity to submit written testimony concerning **HB 5447, An Act Concerning Prior Authorization For Health Care Provider Services.** Nuvance Health and our Connecticut hospitals in Danbury, New Milford, Norwalk and Sharon supports legislative action to address serious problems with the conduct of prior authorization; however, this bill as written does not protect patients or their providers.

Some specific examples of this proposals shortcomings are:

- Prior authorizations require time and resources to submit clinical information and follow up on these submissions. Authorization requirements vary from payer to payer and none lend themselves to a smooth process, therefore the resource commitment by internal case managers, discharge planners, and financial clearance representatives is significant. While this task is being done, actual clinical care suffers. With hospitals experiencing staffing shortages, any time taken away from direct clinical care has significant negative impact to our patients.
- Medicare Advantage plans are challenging to handle in terms of prior authorization for surgical, outpatient, and inpatient services. There is a large administrative burden associated with following their requirements. Specifically the authorization request turnaround time has increased over the past 2 years and now runs between 10 and 15 business days. It is nearly impossible to get an urgent surgical procedure approved (even following the expedited review pathway) in fewer than 5 days. This cause's patient and provider dissatisfaction as patients often have to be rescheduled multiple times, and our staff spend hours calling multiple times to try to push the process along faster.

Issues related specifically to SNF authorization:

- Increased number of denial for SNF coverage
- Family doesn't agree and they are initiating fast track appeal with the payer on many cases
- Issue with Fast track SNF appeal follow up is there doesn't appear to be a clear process available or able to get details from any payer contacts
- When family is calling the payer for initiating appeal against SNF denial they are told the hospital is not providing the correct care
- Finally, patient that switched their insurance from Medicare Advantage to Traditional Medicare have been denied by the SNF due to a (incorrect) medical necessity denial for the hospitalization and have had to pay out of pocket for the SNF themselves

Private health insurance is the source of coverage in the employer-sponsored, small group, and individual insurance markets. Nearly all private health plan coverage arrangements, whether commercial or Medicare Advantage, rely on utilization management, and specifically prior authorization, as a means to gate-keep access to medically necessary services.

Aggressive prior authorization is common throughout the industry. Health plans are using prior authorization to restrict access to patients' covered services. Moreover, they are continually changing the rules that govern prior authorization, often in the middle of provider-insurer contract periods. While the stated intent of prior authorization is to help ensure patients receive care that is safe, efficacious, and beneficial to the individual patient, we have observed that many health plans are applying prior authorization requirements in ways that impact care.

Frequently, health plans establish different requirements for the information a provider must include in a prior authorization request for a particular covered benefit, and health plans often change those requirements unilaterally throughout a contract term.

Delays are most common when patients come in after hours or on weekends when most health plans do not have staff available to review routine requests. Delaying care by keeping a patient in the emergency department or an inpatient bed while waiting for a plan's decision or response to a prior authorization request is not in the best interest of the patient. We strive to ensure that patients are receiving the right level of care when they need it. When patients wait for transfer to settings that focus on both medical and rehabilitative needs, their progress toward recovery can be negatively affected.

During a time of national emergency where workforce shortages and strained health system capacity have been persistent challenges, there is simply insufficient bandwidth to comply with such cumbersome administrative procedures. Hospitals often have multiple full-time employees whose sole role is to manage health plan prior authorization requests. Prior authorization processes exacerbate workforce challenges and contribute to physician and other staff burnout. Expending staff resources to respond to health plan administrative requirements is unreasonable at any time, and far worse as we confront unprecedented and likely enduring challenges recruiting and retaining essential healthcare workers.

We strongly urge you not simply study the issue but to enact real prior authorization reform this session.

Thank you for considering our testimony. For additional information, contact **me at Rowena.Bergmans@nuvancehealth.org**.